



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR MONZER H YAZJI
502 SOUTH CLOSNER
EDINBURG TX 78539

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-12-3504-01

MFDR Date Received

AUGUST 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The information you are requesting is enclosed and provides all the necessary data to process the claim for proper reimbursement."

Amount in Dispute: \$3,015.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor is Dr. M. Yazji, M.D. The requestor billed the technical component of codes 95903, 95904, 95934, 95900, and 95861 for services provided on 4/26/12...Included in the DWC-60 packet is a test report dated 4/26/12. That report indicates the technician who actually carried out the technical component of the testing was Dr. Martinez. The same report also shows the requestor as the referring doctor although the documentation in the DWC-60 has him as the billing provider. For this reason Texas Mutual declined to issue payment to the requestor absent substantiations by the documentation that he performed the technical component of the test. For this reason no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2012	CPT Code 95903-TC (x6)	\$1,200.00	\$0.00
	CPT Code 95904-TC-59 (x4)	\$600.00	\$0.00
	CPT Code 95934-TC-59 (x2)	\$190.00	\$0.00
	CPT Code 95900-TC-59 (x6)	\$900.00	\$0.00
	CPT Code 95861-TC (x1)	\$125.00	\$0.00
TOTAL		\$3,015.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §401.011, effective September 1, 2009 defines a health care provider.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for submitting medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code.)
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 724-No additional payment after reconsideration of services.

Issues

1. Is the requestor a health care provider per Texas Labor Code §401.011(22)?
2. Was the disputed bill submitted in accordance with 28 Texas Administrative Code §133.20 (d)? Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code §401.011(20) defines a "Health care facility" means a hospital, emergency clinic, outpatient clinic, or other facility providing health care."

The requestor Dr. Monzer H Yazji is not a health care facility as defined in Texas Labor Code §401.011(20).

Texas Labor Code §401.011(21) defines "Health care practitioner" means:

- (A) an individual who is licensed to provide or render and provides or renders health care; or
- (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor."

The requestor Dr. Monzer H Yazji is a health care practitioner as defined in Texas Labor Code §401.011(21).

Texas Labor Code §401.011(22) defines "Health care provider" means a health care facility or health care practitioner.

As stated above, Dr. Yazji is a health care provider as defined in Texas Labor Code §401.011(22).

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "225."

28 Texas Administrative Code §133.20 (d), states in part "The health care provider that provided the health care shall submit its own bill".

The respondent states in the position summary that "The requestor billed the technical component of codes 95903, 95904, 95934, 95900, and 95861 for services provided on 4/26/12...Included in the DWC-60 packet is a test report dated 4/26/12. That report indicates the technician who actually carried out the technical component of the testing was Dr. Martinez. The same report also shows the requestor as the referring doctor although the documentation in the DWC-60 has him as the billing provider."

A review of the submitted Lonestar report lists Dr. Martinez as the technician, and Dr. Yazji as the referring physician.

The documentation does not support that Dr. Yazji performed the technical procedure for the disputed services. Therefore, the submitted bill was not submitted in accordance with 28 Texas Administrative Code §133.20 (d). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	8/8/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.